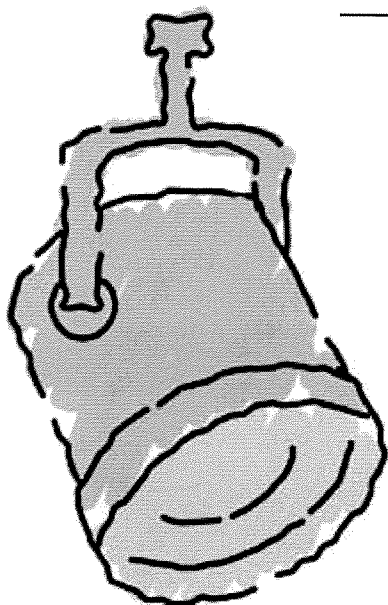


Hawaii Employer-Union Health Benefits Trust Fund

Effective July 1, 2003

Reference Guide for Active Employees



New Plan Highlights

- ▶ PPO Plan with prescription drug coverage and chiropractic coverage.
- ▶ HMO Plan with prescription drug coverage and chiropractic coverage.
- ▶ Dental Plan with orthodontia benefits.
- ▶ Vision coverage.
- ▶ Increased life insurance benefits.
- ▶ For employees who also have coverage elsewhere, dual coverage plans are available for medical, drug, chiropractic, dental and vision benefits.
- ▶ Student coverage to age 24.

Reference Guide for Active Employees

Table of Contents

	Page
Introduction.....	3
Background	3
Open Enrollment.....	3
Open Enrollment Checklist.....	3
2003 Open Enrollment Meeting Schedule	4
Employee-Beneficiary Responsibilities.....	6
Enforcement Actions of the Fund.....	6
Active Employee Eligibility	7
Enrollment	8
Administrative Appeals	9
Enrollment/Change Form Instructions	10
Rates	11
Enrollment/Change Form	Following 11
Instructions to Complete the Designation of Beneficiary Form	14
Designation of Beneficiary Form	Following 14
Medical – PPO Plan.....	16
Medical – PPO Plan Prescription Benefits	18
Medical – HMO Plan.....	19
Dual-Coverage Medical Benefits – Royal State National Insurance Company, Limited	23
Dual-Coverage PPO Plan Prescription Benefits	24
Chiropractic Coverage	25
HDS Dental Plan	26
Dual Coverage Dental Plan.....	27
VSP Vision Plan.....	28
Dual Coverage Vision Plan	28
Life Insurance Benefits	29
Long-Term Care Plan	30
Important Notices	32
Women's Health & Cancer Rights Act.....	32
Newborns' & Mothers' Health Protection Act	32
Qualified Medical Child Support Order	32
National Medical Support Notices	32
Continuation of Group Coverage Under COBRA	33
HIPAA Initial Notice: Notice of Privacy Rules	35

INTRODUCTION

This benefits booklet is designed to help public employees understand the benefit options available and assist them to enroll or change their enrollment in the benefit plans offered by the Hawaii Employer-Union Health Benefits Trust Fund (EUTF). This booklet will also be available at the EUTF's website, www.eutf.hawaii.gov, where you can easily access it when you have questions about your benefits.

This booklet will first serve to guide public employees through the open enrollment process for benefits effective on July 1, 2003. Subsequently, newly hired or newly eligible employees will receive this booklet to use for their first enrollment in the benefit plans.

BACKGROUND

The EUTF was established by Act 88 during the 2001 legislative session. The act was then codified in Chapter 87A, Hawaii Revised Statutes. Chapter 87A established the EUTF Board of Trustees as its governing body and is comprised of ten trustees who are appointed by the Governor of Hawaii. Five of the trustees represent the employers and five represent the employee-beneficiaries. Of the five employee-beneficiary trustees, one trustee represents the state and county retirees. The EUTF, which is administratively attached to the Department of Budget and Finance, is responsible for the daily administrative activities related to the health and life insurance benefits for public employees.

OPEN ENROLLMENT

The open enrollment period is May 1 through May 31, 2003. Each active employee is receiving this booklet along with a pre-completed Enrollment/Change Form for Active Employees (EC-1) that contains the information that EUTF had available as of the beginning of April 2003. Each employee is asked to review the information for accuracy and make any changes that are needed. You may cross out any information that should be deleted and print legibly any new information. If you misplace your pre-completed EC-1, please complete a new EC-1 form. Because the EUTF's plans are new, **every** employee must return the EC-1 and Designation of Beneficiary form. **If you do not return the signed EC-1 to your Department Personnel Officer (DPO) by May 31, 2003, you may lose coverage on July 1, 2003.**

The EUTF invites you to attend Open Enrollment informational sessions. The sessions shown on the following pages are confirmed as of the time this booklet went to press. Please check with our website, www.eutf.hawaii.gov, for the most current schedule.

These meetings are offered so that you can meet with your insurance carriers to learn more about your EUTF benefit plans. Since this is a transition from the current Public Employees Health Fund and the Union plans, the meetings will begin with a half-hour overview of the changes in benefits. The remaining time is for you to meet with the insurance carriers and the EUTF staff. When you attend a meeting, please bring your pre-completed EC-1 form.

OPEN ENROLLMENT CHECKLIST

Late April 2003:

- ✓ Receive Open Enrollment materials.

May 2003:

- ✓ Review your pre-completed Enrollment/Change Form for Active Employees.
- ✓ Verify information and plan preferences; make changes as needed.
- ✓ Sign the Enrollment/Change Form for Active Employees.
- ✓ Complete and sign the life insurance Designation of Beneficiary Form.
- ✓ Submit the signed Enrollment/Change Form for Active Employees and the completed and signed Designation of Beneficiary Form to Department Personnel Officer.

June 2003

- ✓ Receive enrollment confirmation from EUTF. Verify accuracy and notify EUTF of any problems.

July 2003

- ✓ Benefits are effective.
- ✓ Use the enrollment confirmation as a temporary ID until identification cards arrive. Only HMSA and HDS will be issuing new ID cards to all members. The new ID cards will include the new group numbers.

2003 OPEN ENROLLMENT MEETING SCHEDULE

Addresses for each location are listed at the end of the meeting schedule.

OAHU

Date	Start Time	End Time	Location
April 28	8:00 AM	11:00 AM	UH - Kuykendall Auditorium
April 29	8:00 AM	10:00 AM	UH - Kuykendall Auditorium
April 29	1:00 PM	3:00 PM	UH - Kuykendall Auditorium
May 01	9:00 AM	11:00 AM	Department of Labor & Industrial Relations Room 310-14
May 01	1:00 PM	3:00 PM	Department of Labor & Industrial Relations Room 310-14
May 03	9:00 AM	11:00 AM	UH - Hemenway Theatre
May 03	1:00 PM	3:00 PM	UH - Hemenway Theatre
May 06	9:00 AM	11:00 AM	Leeward Community College GT 105
May 07	9:00 AM	11:00 AM	Mabel Smythe Auditorium
May 07	1:00 PM	3:00 PM	Mabel Smythe Auditorium
May 08	4:00 PM	7:00 PM	Leeward Community College GT 105
May 10	1:00 PM	3:00 PM	Aiea High School Cafeteria
May 12	9:00 AM	11:00 AM	Department of Labor & Industrial Relations Room 310-14
May 12	1:00 PM	3:00 PM	Department of Labor & Industrial Relations Room 310-14
May 20	9:00 AM	11:00 AM	UH - Kuykendall Auditorium
May 20	1:00 PM	3:00 PM	UH - Kuykendall Auditorium
May 21	9:00 AM	11:00 AM	State Office Tower Room 204
May 21	1:00 PM	3:00 PM	State Office Tower Room 204
May 27	1:00 PM	4:00 PM	State Capitol Auditorium
May 28	1:00 PM	4:00 PM	State Capitol Auditorium
May 29	1:00 PM	4:00 PM	State Capitol Auditorium
May 30	2:00 PM	4:00 PM	State Capitol Auditorium

HAWAII

May 02	10:00 AM	1:00 PM	Kailua-Kona Gym
May 02	3:00 PM	6:00 PM	Kailua-Kona Gym
May 03	11:00 AM	1:00 PM	Kealakehe High School Cafeteria
May 03	2:00 PM	4:00 PM	Kealakehe High School Cafeteria
May 08	1:00 PM	3:00 PM	Aunty Sally Kaleohano's Lu'au Hale
May 15	9:00 AM	11:00 AM	Aunty Sally Kaleohano's Lu'au Hale
May 15	1:00 PM	3:00 PM	Aunty Sally Kaleohano's Lu'au Hale
May 23	9:00 AM	11:00 AM	Waimea State Office Bldg Conference Room
May 23	1:00 PM	3:00 PM	Waimea State Office Bldg Conference Room

OPEN ENROLLMENT MEETING SCHEDULE continued

Date	Start Time	End Time	Location
KAUAI			
April 30	1:00 PM	3:00 PM	Kauai War Memorial Convention Hall
April 30	5:00 PM	7:30 PM	Waimea Neighborhood center
May 01	10:00 AM	12:00 PM	Mahelona Medical Center Hospital
May 01	2:00 PM	4:00 PM	Mahelona Medical Center Hospital
LANAI			
May 09	12:00 PM	4:00 PM	Lanai School Library
MAUI			
April 25	9:00 AM	11:00 AM	War Memorial Gym
April 25	1:00 PM	3:00 PM	War Memorial Gym
May 13	9:00 AM	11:00 AM	War Memorial Gym
May 13	1:00 PM	3:00 PM	War Memorial Gym
MOLOKAI			
May 22	12:00 PM	4:00 PM	Mitchell Pauole Center

Oahu

Aiea High School Cafeteria 98-1276 Ulune Aiea, Hawaii 96701	Department of Labor & Industrial Relations Keelikolani Building, Room 310-14 830 Punchbowl Street Honolulu, Hawaii 96813
Leeward Community College 96-045 Ala Ike, GT 105 Pearl City, Hawaii 96782	Mabel Smythe Auditorium 510 South Beretania Street Honolulu, Hawaii 96813
State Capitol Auditorium 415 South Beretania Street Honolulu, Hawaii 96813	State Office Tower Leiopapa A Kamehameha Building, Room 204 235 South Beretania Street Honolulu, Hawaii 96813
UH - Kuykendall Auditorium 1733 Donaghho Road Honolulu, Hawaii 96822	UH – Hemenway Theatre 2445 Campus Road Honolulu, Hawaii 96822

Hawaii

Aunty Sally Kaleohano's Lu'au Hale 799 Piilani Street Hilo, Hawaii 96720	Kailua-Kona Gym Kekuaokalani Gym 75-5530 Kuakini Highway Kailua-Kona, Hawaii 96740
Kealakehe High School Cafeteria 74-5000 Puohulihuli Street Kailua-Kona, Hawaii 96740	Waimea State Office Bldg Conference Room 67-5189 Kamamalu Street Kamuela, Hawaii 96743

Kauai

Kauai War Memorial Convention Hall
4191 Hardy Street
Lihue, Hawaii 96766

Waimea Neighborhood Center
(next to Waimea High School)
Waimea, Hawaii 96796

Mahelona Medical Center Hospital
4800 Kawaihau Road
Kapaa, Hawaii 96746

Molokai

Mitchell Pauole Center
Kaunakakai, Hawaii 96748

Lanai

Lanai School Library
Lanai, Hawaii 96763

Maui

War Memorial Gym
Kaahumanu Street
Wailuku, Hawaii 96793

Employee-Beneficiary Responsibilities

Employee-beneficiaries are responsible for:

- ▶ Providing current and accurate personal information as prescribed in this booklet
- ▶ Paying the employee's premium contributions in the amount or amounts provided by statute, an applicable bargaining unit agreement, or by the applicable Fund benefit plan;
- ▶ Paying the employee's premium contributions at the times and in the manner designated by the board; and
- ▶ Complying with the Fund's rules.

Any public employer whose current or former employees participate in Fund benefit plans is responsible for:

- ▶ Providing information as requested by the Fund under section 87A-24(9) of the Hawaii Revised Statutes;
- ▶ Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the board;
- ▶ Assisting the Fund in distributing information to and collecting information from the employee-beneficiaries; and
- ▶ Complying with the Fund's rules.

Enforcement Actions of the Fund

Verifications

The EUTF may require periodic verification of eligibility for employee-beneficiaries and dependent-beneficiaries enrolled by an employee-beneficiary in EUTF benefit plans. The board may set standards and procedures for the required verification. If verification is not provided in accordance with the standards and procedures established by the board, the dependent-beneficiary's enrollment shall be cancelled as set forth in the Administrative Rules. The Administrative Rules are available at the EUTF website, www.eutf.hawaii.gov.

Contribution Shortages

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the Fund. The notice shall be sent within fifteen days of the date on which the required semi-monthly contribution payment was due. The notice shall require the employee-beneficiary to make full payment of the contribution shortage prior to the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due.

Regardless of whether or not the notice of contribution shortage is received by the employee-beneficiary, if the employee-beneficiary fails to make full payment by the last day of the second pay period immediately following the

date that the required semi-monthly contribution payment was due, the employee-beneficiary's enrollment in the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under such enrollment shall be canceled as set forth in Rule 4.12(c).

Cancellation of an employee-beneficiary's coverage pursuant to this rule shall not affect the Fund's right to collect any and all contribution shortages from the employee-beneficiary.

Other Actions

The Fund shall have the right and authority to file actions in any court, including but not limited to the courts of the State of Hawaii and the United States of America, to enforce the foregoing obligations and to collect premium contributions. Nothing in this rule is intended to limit or restrict the rights or remedies otherwise available to the Fund.

Active Employee Eligibility

Eligibility for coverage is determined by the Administrative Rules adopted by the EUTF. Enrollments, terminations, and other changes must be presented through your employer to the EUTF. If you have any questions concerning eligibility provisions, you should check with your DPO, call the EUTF Customer Service at 808-586-7390 or reference the Administrative Rules posted on the EUTF website, www.eutf.hawaii.gov.

Health Plans

Employee-beneficiaries. The following persons shall be eligible to enroll as employee beneficiaries in the benefit plans offered or sponsored by the Fund:

- ▶ An employee, including an elective officer of the State, county or legislature
- ▶ A retired employee
- ▶ Surviving spouse of an employee killed in performance of duty, spouse does not remarry
- ▶ Surviving spouse of retired employee, spouse does not remarry
- ▶ Unmarried child of an employee killed in performance of duty providing child is under 19 and has no surviving parent
- ▶ Unmarried child of retiree and under 19 with no surviving parent.

Dependent-beneficiaries. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund:

- ▶ Spouse or domestic partner (DP)
- ▶ Unmarried children under age 19 or full-time student under the age of 24
- ▶ Unmarried child incapable of self-support due to mental/physical incapacity that existed prior to age 19
- ▶ Child covered by terms of a qualified medical child support order (QMCSO).

Long-Term Care

The following persons shall be eligible, provided that they meet the age, enrollment, medical underwriting and contribution requirements of such plans:

1. Employee-beneficiaries and their spouses, parents, and grandparents;
2. Employee-beneficiaries' in-law parents and grandparents; and
3. Qualified-beneficiaries who enroll between the ages of twenty and eighty-five.

Group Life Insurance

Employees and retired employees are eligible for any group life insurance plans offered or sponsored by the Fund, provided that they comply with the age, enrollment, underwriting, and contribution requirements of such plans.

Special Eligibility Requirements

Student

A child aged 19 through 23 is eligible if attending a full-time accredited college, university or technical school. This includes children who are away at school and dependent upon you for support.

Domestic Partner

Person in a spouse-like relationship with an employee-beneficiary who meets the following requirements:

1. Intend to remain in a domestic partnership with each other indefinitely
2. Have a common residence and intend to reside together indefinitely

3. Jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care
4. Neither are married or a member of another domestic partnership
5. Not related by blood in a way that would prevent them from being married to each other in the State of Hawaii
6. Both at least 18 years of age and mentally competent to contract
7. Consent to the domestic partnership not been obtained by force, duress or fraud
8. Both sign and file a declaration of domestic partnership (affidavit) with the Fund. You may request the affidavit from your DPO or obtain one from the EUTF website, www.eutf.hawaii.gov.

Enrollment

You are not covered until you enroll in the EUTF benefit plans. During Open Enrollment 2003 you must return either your pre-completed or newly completed EC-1 form with all the information requested. Subsequently, those who become eligible must complete an EUTF Enrollment/Change Form for Active Employees (EC-1).

If you do not enroll all eligible members of your family within 30 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so. Open Enrollment periods generally occur once a year, usually two to three months prior to July 1. Coverage dates for all plans begin July 1 and end June 30 of the following year.

Dual Enrollment Is Not Allowed

No one may be enrolled as both an employee-beneficiary and a dependent-beneficiary. If you and your spouse both work for the State or County, you may each enroll for Self Only coverage or one of you may enroll for Family coverage.

Change of Coverage

To change your coverage, you should contact your human resource representative and complete an EC-1. You are eligible to change your coverage outside the Open Enrollment period under the following circumstances:

1. You marry and want to enroll your spouse and newly eligible dependent children.
2. You need to enroll a newborn or newly adopted child.
3. You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death, child marries, no longer lives with you, or turns 19 or 24 for student).
4. Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage.
5. You move out of your plan's service area.

Effective Dates of Coverage

For new hires, the effective date of coverage is the first day of work. There is no waiting period following your date of hire before your health benefits coverage begins, provided you submit a completed EUTF EC-1 to your employer within 30 days of your hire date. Your enrolled eligible dependents' coverage is effective the same date as yours.

Although your coverage begins immediately, payroll deductions for your premiums will not begin until the first day of the second pay period after your hire date.

If you were enrolled in the EUTF with your previous public employer and your coverage is still in effect on the day you begin work with your current employer (COBRA coverage excluded), your coverage begins immediately – so you have no break in coverage. (See Transfer of Employment, below.)

Coverage changes involving the addition of dependents are effective retroactive to the date of the event (marriage, birth, adoption, etc.) providing the application is filed within 30 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the EUTF. Dependent children are automatically terminated as of the end of the pay period they attain age 19 or 24, in the case of full-time students, and do not require the completion of an application to delete coverage.

Transfer of Employment

If you transfer from one EUTF employer to another, including transfers within State and/or County employment, coverage will be continued provided that you are still covered by the EUTF (COBRA coverage excluded) when you begin your new position.

If you transfer employment within 90 calendar days of the last day of employment with the previous employer, you will not be subject to Act 217, SLH 1995 as amended. Act 217 states that the employer contribution for retiree benefits will be determined as follows:

- ▶ If you were employed prior to July 1, 1996 and retire with 10 or more years of service, excluding sick leave, you will receive 100% employer contribution funding.
- ▶ If you were employed or re-employed more than 90 days after the last day worked with the previous employer, after June 30, 1996 with less than 10 years of service, the funding of your retiree benefits will be:

Years of Service, Excluding Sick Leave	Employer Funding
10 but fewer than 15	50%
15 but fewer than 25	75%
25 or more	100%

End of Coverage

Coverage for you and your dependents will end if:

1. You voluntarily terminate coverage
2. Your employment terminates
3. Your hours are reduced so you no longer qualify for coverage;
4. You do not make required premium payments;
5. You die except for certain exceptions;
6. Your employer ceases to participate in the EUTF; or
7. The EUTF is discontinued.

Coverage for your dependents will end if your coverage ceases for any of the reasons listed above or:

1. Your dependent is no longer eligible for coverage (divorce of a spouse; children marry, move out of the household, or turn age 19, or 24 if a student unless the dependent child qualifies for continuance of coverage due to disability);
2. Your enrolled dependent enters the uniformed services.

Effective Date of Termination

In general, coverage ends on the first day of the pay period after the event giving rise to the end of coverage. There may be certain instances in which the effective date is different. You may obtain additional information from your DPO or by referring to the EUTF Administrative Rules that are posted on the EUTF website, www.eutf.hawaii.gov.

Enrollment in EUTF benefit plans is contingent on meeting all eligibility criteria outlined on the previous pages and detailed in the Administrative Rules. Any enrollment application may be rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.

An enrollment application shall be rejected if:

1. The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
2. The application is not filed within the time limitations prescribed by the rules;
3. The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
4. The employee-beneficiary owes past due contributions or other amounts to the Fund; or
5. Acceptance of the application would violate applicable federal or state law or any other provision of the rules.

Employee-beneficiaries will be notified of the rejection of any enrollment application.

Administrative Appeals

A person aggrieved by one of the following decisions by the Fund may appeal to the board for relief from that decision:

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the Fund;
2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the Fund; or

4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the Fund.

The first step in the appeal process is an appeal to the administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the Fund's office within thirty days of the date of the decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the administrator nor the board shall be required to hear any appeal that is filed after the thirty-day period has expired. The written appeal need not be in any particular form but should contain the following information:

1. The aggrieved person's name, address, and telephone number;
2. A description of the decision with respect to which relief is requested, including the date of the decision;
3. A statement of the relevant and material facts; and
4. A statement as to why the aggrieved person is appealing the decision, including the reasons that support the aggrieved person's position or contentions.

If the aggrieved person is dissatisfied with the administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within ninety days of its being filed in the Fund's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the board. A written appeal to the board must be filed in duplicate in the Fund's office. The written appeal need not be in any particular form but shall contain the following information:

1. The aggrieved person's name, address and telephone number;
2. A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;
3. A description of the decision with respect to which relief is requested, including, the date of the decision;
4. A complete statement of the relevant and material facts;
5. A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
6. A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

Subject to applicable federal and state law, the board may reject any appeal that does not contain the foregoing information.

The board at any time may request the aggrieved person or any other party to the proceeding to submit a statement of additional facts or a memorandum, the purpose of which is to clarify the party's position or a specific factual or legal issue.

The board shall grant or deny the appeal within a reasonable amount of time. The board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the board may set such hearing before the board, a special, or standing committee of the board, a hearings officer, or any other person or entity authorized by the board to hear the matter in question. Nothing in these rules shall require the board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the Rule by submitting such a waiver in writing to the Fund's office. The board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

Enrollment/Change Form Instructions

This Enrollment/Change Form for Active Employees (EC-1) will be used to enroll new employees or to make changes as allowed by law or the EUTF rules. Prior to the open enrollment period, the EUTF will send to each employee a pre-completed copy of the EC-1. Make any changes on the form, sign it and turn it in to your DPO. Each employee should keep a copy of the signed form that reflects their open enrollment choices.

For New Hires or those completing a blank application form:

Items 1 – 7: Please complete as applicable.

Item 8: You have enrollment choices in three categories: Medical (includes Prescription Drug and Chiropractic), Dental and Vision. In each category you may only select one option. For each option you select, you may choose coverage for yourself only or for your family.

When you choose a medical plan, you are also enrolled in the prescription drug plan and in the chiropractic plan. If you choose not to enroll in the medical plan, you will also be ineligible for the prescription drug and chiropractic plans.

You must select your dental and vision plans individually. These plans are not bundled with the medical plan.

You may select a Dual Coverage plan only if you are covered by another plan, not offered by EUTF, in the same category.

Item 9: This section is for State of Hawaii employees only. By electing to participate in the Premium Conversion Plan (PCP), please note that:

1. Your authorization will automatically continue year-to-year for the duration of the plan until you change or cancel your participation in the PCP during the Open Enrollment period or as provided under number 2 below;
2. If you have an allowable change in status (marriage, birth or adoption of children, divorce, etc.), you must complete/file all the required PCP forms within 30 days of the event, to change or cancel your reduction in pay (otherwise, changes can be made only during the Open Enrollment period);
3. Allowable changes/cancellations will generally take effect the month after you file, so to avoid the risk of losing money, you need to file the forms as soon as possible;
4. Your election, in the absence of an allowable change in status, cannot be changed for the current plan year; and
5. If you change/cancel your health insurance plan coverage, but your PCP change/cancellation is not allowable, your PCP authorization will still remain in effect through the end of the plan year, and your payments will be forfeited, until PCP change/cancellation forms are filed and approved during the next Open Enrollment period.

Be sure to read the PCP brochure for an overview of the plan. If you need more information or a copy of the complete PCP Administrative Rules, please contact your personnel office.

Note: Everyone enrolled in the PCP will be cancelled effective June 30, 2003. Therefore, employees who wish to continue this tax-saving benefit must re-enroll in PCP by marking the appropriate box on the EC-1 form.

Item 10: You must sign and date this form before you turn it in to your personnel office. Be sure to note that your signature represents certain affirmations about the coverages you are selecting and the members of your family whom you are listing as dependents.

Item 11. Please list all of your dependents and provide the information requested. If you are listing a child aged

19 through 23, they must be attending an accredited college, university or technical school as a full-time student.

If you are enrolling a child incapable of self-support due to mental or physical incapacity that existed prior to age 19, please circle "Disabled."

If you are enrolling a domestic partner, you must submit an affidavit declaring your domestic partnership. Please request the affidavit from your personnel office or obtain one from the EUTF website, www.eutf.hawaii.gov.

Note: You are automatically enrolled in the EUTF's life insurance plan. The employer pays premiums in full. If you wish not to have the life insurance coverage, please call the EUTF at 808 586-7390 and request a form to waive coverage.

Rates

At the time this booklet went to press, collective bargaining was not complete. The monthly rates presented here are the full monthly premiums for these coverages. When collective bargaining is complete you will be informed how much of the premiums will be paid by the employer.

Single Coverage

HMSA PPO, Drug and Chiropractic	\$233.54
Kaiser HMO, Drug and Chiropractic	\$220.60
Royal State Dual Coverage with HMSA Drug and Chiropractic	\$138.32
HDS Dental	\$24.44
HDS Dual Coverage Dental	\$14.46
VSP Vision	\$5.96
VSP Dual Coverage Vision	\$3.38

Family Coverage

HMSA PPO, Drug and Chiropractic	\$697.64
Kaiser HMO, Drug and Chiropractic	\$654.72
Royal State Dual Coverage with HMSA Drug and Chiropractic	\$416.78
HDS Dental	\$69.28
HDS Dual Coverage Dental	\$41.34
VSP Vision	\$12.74
VSP Dual Coverage Vision	\$7.24

EUTF Enrollment/Change Form for Active Employees

1. Social Security No.	2. Employee's Name (Last, First, M.I.)	3. Date of Birth Month / Day / Year / /	
4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		5. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	
6. Phone Number - Home	7. Street Address		
6a. Phone Number - Work	7a. City	7b. State	7c. Zip code

8. Plan Selections, Changes or Cancellations

First, decide the coverage you want, "Self" or "Family." Please make your selection by checking the blocks for appropriate benefit plans below. The medical, drug and chiropractic plans are available as a bundle. You cannot enroll in any one of them individually. You are only eligible for the dual coverage plan if you have medical, dental or vision coverage from a source other than the EUTF.

Medical, Drug, Chiropractic (choose one)

HMSA PPO Medical and Drug, MBAH ChiroPlan

Kaiser Medical and Drug, MBAH ChiroPlan

Royal State Dual Coverage Medical with HMSA Drug and MBAH ChiroPlan

<u>Self</u>	<u>Family</u>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Dental (choose one)

HDS Dental

HDS Dual Coverage Dental

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Vision (choose one)

VSP Vision

VSP Dual Coverage Vision

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

9. State of Hawaii Employees Only – I HEREBY ELECT TO (choose one):

- ☐ ENROLL in the Premium Conversion Plan (PCP) so that my monthly employee contribution (premium) for my health insurance benefit plans will be paid using pre-tax payroll deducted monies, to the extent permitted. I have read and understand the PCP General Information section in the benefit booklet.
- ☐ NOT ENROLL in the Premium Conversion Plan, and instead, use after-tax payroll monies for my monthly premiums.
- ☐ CHANGE the amount of my PCP reduction for the plan(s) checked in number 8 above.
- ☐ CANCEL my PCP reduction for the plan(s) checked in number 8 above.

10. Certification: I certify that the information provided in this application is true and complete. I agree to abide by the terms and conditions of the benefit plans I selected. I authorize my employer or finance officer to set my effective dates of coverage and to make the pre-tax or after-tax deductions, adjustments or cancellations from my salary, wages, pension or other compensation for my monthly employee contribution in accordance with applicable laws, rules and regulations.

I affirm that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student.

I affirm that I have non-EUTF plan benefits for each Dual Coverage Plan I selected.

Signature _____ Date: _____

EUTF Enrollment/Change Form for Active Employees

11. If you made a "Family" coverage selection in Section 8, list all dependents to be covered, including your Spouse, Domestic Partner, Children or Students. If you are adding a Domestic Partner (DP), please refer to the instructions. If you are enrolling a domestic partner's child, please circle both the Child and DP relationship. Codes for the Action column are: A – Add; C – Change Information, D – Delete Coverage

First Name, M.I., Last Name (if different from employee)	Date of Birth (MM/DD/YY)	Social Security Number	Relationship (Circle One)	Gender (Circle One)	Action
			Spouse	M F	
			DP	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	

Other Information or Comments:

.....

.....

.....

.....

.....

For DPO USE:

12. Employer (Check One) <input type="checkbox"/> State of Hawaii <input type="checkbox"/> County of Kauai <input type="checkbox"/> C&C of Honolulu <input type="checkbox"/> County of Maui <input type="checkbox"/> County of Hawaii <input type="checkbox"/> Bd. Of Water Supply	13. Department Division or School	14. Date of Coverage	15. Bargaining Unit
--	---	-----------------------------	----------------------------

I certify that the applicant is an eligible employee-beneficiary as defined in Chapter 87A, HRS.

DPO Signature _____ Date: _____ Phone: _____

For DPOs: Fax the completed form to EUTF at 808-586-2161, make a copy for your records, and then, process this form in accordance with your departmental policies and procedures.

Instructions to Complete the Designation of Beneficiary Form



Life insurance benefits are described later in this booklet. If you do not wish to have life insurance coverage please contact the EUTF at 808-586-7390 to request a form to waive your coverage.

Please use only black ink to complete the form.

If you make a mistake in completing the form, line out the erroneous information, add the correct information and initial the correction. The printed material on the form should not be deleted or altered in any way.

In all cases, the relationship of the beneficiary and the beneficiary's social security number should be included with the beneficiary designations.

If a beneficiary is to be contingent, be sure to check the appropriate box. A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) does not survive the insured. If naming more than one Contingent Beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc.

If a married woman is named beneficiary, her full legal name should be shown. For example: Mary J. Smith, not Mrs. John J. Smith. Likewise, if this form is to be signed by a married woman, she should sign her full legal name.

If a minor child is named beneficiary, the date of birth along with the child's social security number must be given.



Conditions – When you sign the form you are agreeing to these conditions:

Unless otherwise expressly provided in this Designation of Beneficiary form, if any named beneficiary predeceases you, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives you, any sum becoming payable under said Group Policy(ies) by reason of your death shall be payable as prescribed in said Group Policy(ies).

If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.

If you live in one of the following community property states - Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin - your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved. If you make the beneficiary someone other than your spouse, it may be a good idea to complete the spousal consent section, which allows the spouse to waive his or her rights to any community property interest in the benefit.

When two or more beneficiaries are named, and they are not to share the benefits equally, enter the percentage each beneficiary is to receive on the form in the space provided. Dollars and cents should not be specified. When added together, the sum of the percentages going to the two or more named beneficiaries must total 100%.

If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee.

For example: The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith, Trustee, 123 Apple Lane, Hartford, CT 06006.



Aetna Life Insurance Company

Designation of Beneficiary

Please keep a copy for your records.

Group Policyholder Name Hawaii Employer-Union Health Benefits Trust Fund	Group Policy Number 881930
Employee/Retiree Name and Address	Employee/Retiree Social Security Number

Subject to the terms of the above numbered Group Policy(ies), I request that any sum becoming payable by reason of my death be payable to the following beneficiary(ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary and all elections of optional methods of settlement previously made by me under said Policy(ies). If this Designation of Beneficiary refers only to a Group Life Insurance Policy and if I am also insured for Supplemental and/or Group Accidental Death coverage, this designation shall apply to those coverages. This Designation of Beneficiary is subject to all "Conditions" shown in the instructions located in the benefit booklet.

Employee/Retiree Signature		Date	
Beneficiary Name and Address <input checked="" type="checkbox"/> Primary Beneficiary*			
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
Beneficiary Name and Address (Please check one) <input type="checkbox"/> Primary Beneficiary* or <input type="checkbox"/> Contingent Beneficiary**			
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
Beneficiary Name and Address (Please check one) <input type="checkbox"/> Primary Beneficiary* or <input type="checkbox"/> Contingent Beneficiary**			
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
Beneficiary Name and Address (Please check one) <input type="checkbox"/> Primary Beneficiary* or <input type="checkbox"/> Contingent Beneficiary**			
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
Beneficiary Name and Address (Please check one) <input type="checkbox"/> Primary Beneficiary* or <input type="checkbox"/> Contingent Beneficiary**			
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

*If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above.

**Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc. in the order of precedence.

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES ONLY*** - See Conditions in the booklet

*** Please note that an employee/retiree is under no obligation to complete the Spousal Consent section of this form.

I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature _____ Date _____

Medical - PPO Plan



The medical PPO plan is offered through HMSA. This summary is intended to provide a condensed explanation of plan benefits. For complete information on benefits and provisions, please refer to the Guide to Benefits or certificate, which may be obtained by calling HMSA or from the EUTF website www.eutf.hawaii.gov. In the case of a discrepancy between this summary and the language contained within the Guide to Benefits, the Guide to Benefits will take precedence.

If you have any questions, please contact HMSA at any of the following locations:

Oahu 818 Keeaumoku Street
Honolulu, HI 96814
Phone: (808) 948-6499

Hawaii 670 Ponahawai Street, Suite 121 75-166 Kalani Street, Suite 202
Hilo, Hawaii 96720 Kailua-Kona, Hawaii 96740
Phone: (808) 935-5441 Phone: (808) 329-5291

Kauai 4366 Kukui grove Street, Suite 202
Lihue, HI 96766
Phone: (808) 245-3393

Maui 33 Lono Avenue, Suite 350
Kahului, HI 96732
Phone: (808) 871-6295

You may also find answers to your questions at the HMSA website, www.hmsa.com.

Beneficiaries who were covered by HMSA immediately prior to electing this coverage will have previously accrued maximums carry forward and count against the same types of maximum amounts under this coverage.

This medical coverage is combined with benefits for prescription medicines. This section summarizes these benefits.

Lifetime Maximum	\$2,000,000	
Maximum Annual Co-payment	\$1,500 per person	\$4,500 per family
	Participating Provider	Nonparticipating Provider
Hospital Deductible	None	\$200
Annual Deductible	None	\$100 per person/\$300 per family
	Member Copayment	
	Participating	Nonparticipating
Physician Visits	10%	30% after annual deductible
Immunizations including Hepatitis B	None	None
Testing, Laboratory and Radiology ⁽¹⁾ Includes Allergy Testing, Allergy Treatment Materials, Inpatient and Outpatient Diagnostic Testing and Radiology, and Tuberculin Skin Test.	10%	30% after annual deductible
Note: ⁽¹⁾ HMSA may contract with certain laboratory and radiology groups to accept HMSA's payment as payment in full. Members may not have a copayment for services received as part of these types of contractual arrangements.		
Surgical Services	10%	30% after annual deductible
Organ and Tissue Transplants	10%	30% after annual deductible
Transplant Evaluation	None	Not Covered
Chemotherapy and Radiation Therapy	10%	30% after annual deductible

Medical - PPO Plan continued

HMSA



An Independent Licensee of the Blue Cross and Blue Shield Association

Member Copayment		
	Participating/ Contracting	Nonparticipating/ Non- Contracting
Hospital and Facility Services		
Ambulatory Surgical Center (ASC)	10%	30% after annual deductible
Emergency Room	10%	30% after annual deductible
Inpatient Hospital Services	10%	30% after annual & hospital deductible
Skilled Nursing Facility	10%	30% after annual & hospital deductible
Behavioral Health - Mental Health and Substance Abuse		
Mental Health Facility Services	10%	30% after annual & hospital deductible
Mental Health Physician Services – Inpatient	10%	30% after annual deductible
Psychological Testing – Inpatient & Outpatient	10%	30% after annual deductible
Substance Abuse Facility Services	10%	30% after annual & hospital deductible
Substance Abuse Physician Services Inpatient	10%	30% after annual deductible
Other Medical Services and Supplies		
Medical Foods	10%	20%
Private Duty Nursing	Not Covered	Not Covered
Cardiac Rehabilitation	Not Covered	Not Covered
Organ and Tissue Transplants		
HMSA has contracted with certain providers for transplant services. You must receive services from a contracted provider for these benefits to apply.	None	Not Covered
Special Benefits for Disease Management		
Asthma Care Connection	None	Not Covered
Cardiac Care Connection	None	Not Covered
Diabetes Care Connection	None	Not Covered
Special Benefits for Health Assessment and Health Education		
RSVP Screenings Limitations apply.	10%	30% after annual deductible
HealthPass – health and weight measurements, body fat analysis, blood pressure measurements, blood cholesterol, HDL, and glucose screening	None	Not Covered
Health Appraisal Program(2) - Laboratory and X-ray Services & Physical Exams	None	Not Covered
Physical Examinations (2) - Routine annual checkup	Any amount exceeding HMSA's allowance of up to \$41.50 ages 6 – 12 years \$62 ages 13 – 18 years \$113.50 ages 19 – 39 years \$170.00 ages over 40 years	Any amount exceeding HMSA's allowance of up to \$41.50 ages 6 – 12 years \$62 ages 13 – 18 years \$113.50 ages 19 – 39 years \$170.00 ages over 40 years

Note: ⁽²⁾ Coverage includes benefits for either one Health Appraisal Program or one Physical Exam per calendar year.

Medical - PPO Plan Prescription Benefits



An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFITS		MEMBER PAYS	
RETAIL PRESCRIPTION PROGRAM (30 day supply)		Participating Pharmacy	Nonparticipating Pharmacy
Generic		\$5 copayment	\$5 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Preferred Brand Name		\$15 copayment	\$15 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Other Brand Name		\$30 copayment	\$30 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Insulin			
Preferred Insulin		\$5 copayment	\$5 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Other Insulin		\$15 copayment	\$15 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Diabetic Supplies			
Preferred Diabetic Supplies		No copayment	No copayment
Other Diabetic Supplies		\$15 copayment	\$15 copayment
Oral Contraceptives			
Preferred Oral Contraceptives		\$5 copayment	\$8 copayment
Other Oral Contraceptives (including generic contraceptives)		\$30 copayment	\$30 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Diaphragms			
Preferred Diaphragms		\$10 copayment	\$12 copayment
Other Diaphragms		\$20 copayment	\$20 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Spacers ⁽¹⁾		Special Member Rates	Special Member Rates
Peak Flow Meters ⁽¹⁾		Special Member Rates	Special Member Rates
Note: ⁽¹⁾ HMSA has arranged with contracted drug manufacturers to offer spacers for inhaled drugs and peak flow meters at special member rates.			
BENEFITS		MEMBER PAYS	
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)		HMSA Vendor	Non-HMSA Vendor
Generic		\$10 copayment	Not a benefit
Preferred Brand Name		\$35 copayment	Not a benefit
Other Brand Name		\$60 copayment	Not a benefit
Insulin			
Preferred Insulin		\$10 copayment	Not a benefit
Other Insulin		\$35 copayment	Not a benefit
Diabetic Supplies			
Preferred Diabetic Supplies		No copayment	Not a benefit
Other Diabetic Supplies		\$35 copayment	Not a benefit

Medical - HMO Plan



KAISER PERMANENTE®

This is only a summary. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members. In event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control.

You are covered for medically necessary services, within the Hawaii service area, at Kaiser Permanente facilities, and which are provided or arranged by a Kaiser Permanente physician. All care and services need to be coordinated by a Kaiser Permanente physician. For specific questions about coverage, please ask your employer's benefits officer or call Customer Service Center at (808) 432-5955 (Oahu) or 1-(800) 966-5955 (Neighbor Islands). You may also obtain information from the Kaiser Permanente website, www.kaiserpermanente.org.

	Benefits	You pay
Outpatient services	Doctors' and other health practitioners' office visits	\$10 registration fee per visit
	Preventive care	
	Health evaluations for adults	
	Physical examinations for children, and well-baby care	\$10 registration fee per visit
	Immunizations generally available in the Hawaii service area:	
	Immunizations developed and in general use for specific diseases on March 1, 1994	No charge
	Immunizations developed or in general use for specific diseases after March 1, 1994	50% of applicable charges
	- Exception: Immunizations in keeping with "prevailing medical standards" (as defined by State law) for children 5 years of age or under and Hepatitis B	No charge
	Unexpected mass immunizations	50% of applicable charges
	Injectable travel immunizations	50% of applicable charges plus \$10 registration fee
	Oral travel immunizations	\$10 per prescription
	Laboratory procedures, prescribed imaging, and diagnostic services	No charge
	Short-term physical, occupational and speech therapy	\$10 registration fee per visit
	Dialysis	
Hospital inpatient care	Kaiser Permanente physician and facility services for dialysis	\$10 registration fee per visit
	Equipment, training and medical supplies for home dialysis	No charge
	Outpatient surgery and procedures	\$10 registration fee per visit
	Materials for dressings and casts	No charge after \$10 registration fee
	Take-home supplies , such as drug and ostomy supplies, catheters and tubing	Not covered
Hospital inpatient care	Doctors' medical and surgical services	No charge
	Room and board, general nursing, laboratory procedures, prescribed imaging, and diagnostic services	No charge
	Transplants , including kidney, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, small bowel, and small bowel-liver transplants	No charge for the procedure (drugs according to member's drug coverage)

Medical - HMO Plan continued



KAISER PERMANENTE®

Benefits		You pay
Prescribed drugs	<p>Prescribed drugs that require skilled administration by medical personnel (e.g., cannot be self-administered)</p> <p>Prescribed by a Kaiser Permanente licensed prescriber and on the Health Plan formulary, and used in accordance with formulary criteria, guidelines or restrictions</p> <p>Chemotherapy drugs for the treatment of cancer</p> <p>Exclusions: Drugs that are necessary or associated with services that are excluded or not covered</p>	<p>No charge after \$10 registration fee</p> <p>No charge after \$10 registration fee</p>
Prenatal care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services	<p>Prenatal care (prenatal care, delivery, and mother's care in the hospital following delivery)</p> <p>Interrupted pregnancy and family planning services</p> <p>Involuntary infertility services (not including lab, prescribed imaging or drugs)</p> <p>Artificial insemination</p> <p>In vitro fertilization limited to one-time only benefit at Kaiser Permanente limited to female members using spouse's sperm</p>	<p>No charge after confirmation of pregnancy</p> <p>\$10 registration fee per visit</p> <p>\$10 registration fee per visit</p> <p>\$10 registration fee per visit</p> <p>20% of applicable charges (drugs according to member's drug coverage)</p>
Home health care and hospice care	<p>Home health care, nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician. Hospice care. Supportive and palliative care for a terminally ill member, as directed by a Kaiser Permanente physician. Hospice coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. (Hospice benefits apply in lieu of any other plan benefits for treatment of terminal illness.)</p>	No charge
Skilled nursing care	<p>Up to 100 days of prescribed skilled nursing care services in an approved facility (such as a hospital or skilled nursing facility) per benefit period.</p> <p>Exclusions: Personal comfort items, such as telephone, television and take-home medical supplies.</p>	No charge
Emergency services	<p>At a facility <u>within</u> the Hawaii service area for covered emergency services</p> <p>At a facility <u>outside</u> the Hawaii service area for covered emergency services (covered for initial emergency treatment only).</p> <p>Note: Member (or Member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility.</p>	<p>\$25 registration fee per visit, plus other applicable plan charges</p> <p>20% of all Reasonable and Customary charges plus other applicable plan charges</p>

Medical - HMO Plan continued



KAISER PERMANENTE®

Benefits		You pay
Out-of-area urgent care services	At a non-Kaiser Permanente facility for covered urgent care services (Coverage for initial urgent care treatment only and while temporarily outside the Hawaii service area)	20% of all Reasonable and Customary charges plus other applicable plan charges
Ambulance services	Ambulance Services are those services in which: use of any other means of transport, regardless of availability of such other means, would result in death or serious impairment of the member's health, and is for the purpose of transporting the member to receive medically necessary acute care. In addition, if air ambulance, the member's condition must require the services of an air ambulance for safe transport.	20% of all Reasonable and Customary charges
Blood (inpatient or outpatient)	Regardless of replacement, units and processing of units of whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin. Collection, processing, and storage of autologous blood when prescribed by a Kaiser Permanente physician.	20% of applicable charges
	Donor directed units	Not covered
Mental health and chemical dependency services	Up to 24 combined outpatient office visits/calendar year Up to 30 days hospital care per calendar year in total, which can include any combination of hospital days and specialized facility services. (Two (2) days of specialized facility care counts as one (1) hospital day.) Includes Kaiser Permanente physician services Note: Parity coverage for "serious mental illness" (schizophrenia, schizoaffective disorder, and bipolar mood disorder), is provided in accordance with state law.	\$10 registration fee per visit No charge (Mental Health) 20% of applicable charges (Chemical dependency)
Internal prosthetics, devices, and aids	Implanted internal prosthetics (such as pacemakers and hip joints), and internally implanted devices and aids (such as surgical mesh, stents, bone cement, implanted nuts, bolts, screws, and rods) which are medically indicated, prescribed by a Kaiser Permanente physician and obtained from sources designated by Health Plan	20% of applicable charges
	Fitting and adjustment of these devices, including repairs and replacement other than those due to misuse or loss	20% of applicable charges
External prosthetic devices and braces	External prosthetic devices and braces , when prescribed by a Kaiser Permanente physician, and obtained from sources designated by Health Plan	20% of applicable charges
	Fitting and adjustment of these devices , including repairs and replacements other than those due to misuse or loss	20% of applicable charges
Durable medical equipment	Medically necessary and appropriate durable medical equipment for use in the home , when prescribed by a Kaiser Permanente physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan	20% of applicable charges
	Oxygen for use in conjunction with prescribed durable medical equipment	20% of applicable charges
	Repair, replacement and adjustment of durable medical equipment, other than those due to misuse or loss	20% of applicable charges

Medical - HMO Plan continued



KAISER PERMANENTE®

Benefits		You pay
Diabetes equipment	Glucose meters and external insulin pumps (and the supplies necessary to operate them) when Health Plan criteria are met.	20% of applicable charges
Drug	For each prescription, when the quantity does not exceed: a 30-consecutive-day supply of a prescribed drug, or one dose of a self-administered injectable drug, or one cycle of an oral contraceptive drug, or an amount as determined by the Formulary.	\$10 per prescription
	Insulin and certain diabetes supplies	\$10 per prescription
	Oral contraceptive drugs	\$10 for one cycle
	Diaphragms and cervical caps	\$10 each
	Other contraceptive drugs and devices	\$10 times the number of months the drug or device is effective; \$250 maximum
Mail order	Mail order prescription forms may be obtained at any Kaiser Permanente pharmacy, or call the Kaiser Permanente mail order pharmacy at 432-5510, Monday - Friday, 8:30 A.M. to 5:00 P.M. You may purchase a 3 month's supply of maintenance medications at 2 co-payment amounts through Kaiser Permanente's mail order prescription service, restricted to ZIP codes in the Kaiser Permanente service area. Please mail your refill order before you are down to your last 10 days supply. Allow one week to receive your medication for refillable orders. The mail order program does not apply to the delivery of certain pharmaceuticals (i.e., controlled substances as determined by State and/or Federal regulations, bulky items, medication affected by temperature, injectables, and other products and dosage forms as identified by the Pharmacy and Therapeutics Committee).	
Supplemental charges maximum	<p>Your out-of-pocket expenses for covered Basic Health Services are capped each year by a Supplemental Charges Maximum.</p> <p>You must retain your receipts for the charges you have paid, and when the maximum amount has been PAID, you must present these receipts to our Business Office at Moanalua Medical Center, Honolulu Clinic or to the cashier at other clinics. After verification that the Supplemental Charges Maximum has been PAID, you will be given a card which indicates that no additional Supplemental Charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits to get your Supplemental Charges waived.</p> <p>All payments are credited toward the calendar year in which the services were received.</p> <p>Once you have met the Supplemental Charges Maximum, please submit your proof of payment as soon as reasonably possible. All receipts must be submitted no later than February 28 of the year following the one in which the services were received.</p>	<p>\$1,000 per member,</p> <p>\$3,000 per family unit (3 or more members), for calendar year</p>

This is only a summary. It does not fully describe your benefit coverage **nor does it list the majority of the exclusions and limitations for these benefits.** For a summary listing of the benefit exclusions and limitations, please contact the EUTF administrative office or Kaiser Permanente's Customer Service Department. For a full description of your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members. In event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control.

Dual-Coverage Medical Benefits – Royal State National Insurance Company, Limited



This Medical Plan is designed for Active Employees who have medical coverage through private sector or federal government medical plans. This high deductible benefit plan provides an extra level of coverage for medical and hospital expenses in order to help protect against the devastating effects and expenses of a serious illness.

If you have any questions about the plan you may contact Royal State at any of the following locations:

Oahu	The Royal Insurance Agency, Inc. 819 S. Beretania Street Honolulu, HI 96813 Phone: (808) 539-1600 Fax: (808) 539-1728 Out of state: 1-800-890-9022	Hawaii	The Royal Insurance Agency, Inc. 120 Pauahi Street, suite 201 Hilo, HI 96720 Phone: (808) 935-2766 Fax: (808) 935-8918
Maui	The Royal Insurance Agency, Inc. 2145 Kaohu Street, Suite 102 Wailuku, HI 96793 Phone: (808) 244-7245 Fax: (808) 242-8838 Lanai: 1-800-774-7668 Molokai: 1-800-774-7668	Kauai	The Royal Insurance Agency, Inc. Kukui Grove Executive Center 4370 Kukui Grove Street, Suite 105 Lihue, HI 96766 Phone: (808) 245-4571 Fax: (808) 245-3057 Niihau: 1-800-774-6996

This summary is intended to provide a condensed description of plan benefits. For a complete description of the benefits and exclusions, please request a benefit statement from The Royal Insurance Agency. In the case of a discrepancy between this summary and the provisions contained in the plan certificate, the latter will govern. You may also obtain information from Royal State's website, www.royalstate.com or the EUTF website, www.eutf.hawaii.gov.

Annual Deductible	
Single Deductible	\$2,000
Family Deductible	\$6,000
Hospital Per Confinement	None
Lifetime Maximum Benefit	\$500,000
Co-Pay Annual Maximum	None
Family Co-Pay Annual Maximum	None
Service	You Pay
Office Visits	20%
Well Baby Care	20%
Immunizations	No Charge
Hospital	20%
X-Ray & Lab Inpatient	20%
Surgery	20%
Emergency Room	20%
Out-Patient Surgery Centers	20%

Dual-Coverage Medical Benefits – continued

Royal State National Insurance Company, Limited



Service	You Pay
Mental Health	
Inpatient Days Per Year	30
Co-payment	20%
Physicians Visits	20%

Plan - Each covered person has an annual (calendar year) deductible: Single: \$2,000; Family: \$6,000. After the deductible has been met, the plan pays 80% of the allowable charges for covered medical expenses up to a maximum lifetime benefit of \$500,000 per person.

Benefits - The plan provides hospital expenses for room and board for each day of a hospital stay (common semi-private room rates). For intensive care unit rooms, the plan covers up to three times the hospital's most common semi-private room rate. Miscellaneous services are covered for both hospital stays and outpatient care.

Surgical expenses including surgeon; medical expenses other than that for surgery, x-ray or laboratory exams; services of a radiologist, pathologist, and anesthesiologist; oxygen, other gases and the equipment to administer them; blood transfusions; drugs prescribed while hospitalized are covered.

Mammography coverage is included and subject to policy provisions.

Claims - If your other coverage is as a dependent, this Medical Plan becomes the primary insurance coverage for you. This means that you will have to file any claims through this Plan first. To minimize the amount you would have to pay, this Plan will work with your other medical insurance plan to assure that the maximum claim amounts are paid by both insurance plans. Note: if your birthday falls before your spouse's in a calendar year this Plan will be primary for your eligible dependent children as well as yourself.

Dual-Coverage PPO Plan Prescription Benefits

The dual coverage medical plan is bundled with a dual coverage prescription drug plan from HMSA. For complete information on benefits and provisions, please refer to the Guide to Benefits or certificate, which may be obtained by calling HMSA. Please refer to the PPO medical plan pages for HMSA contact information.

BENEFITS	MEMBER PAYS	
RETAIL PHARMACY (30 day supply)	Participating Pharmacy	Nonparticipating Pharmacy
Generic, Preferred Brand Name, Other Brand Name, Insulin, Diabetic Supplies, Oral Contraceptives, Diaphragms	Any eligible charges exceeding HMSA's \$15 payment under this plan	Any charges exceeding HMSA's \$15 payment under this plan
Spacers ⁽¹⁾ and Peak Flow Meters ⁽¹⁾	Special Member Rates	Special Member Rates
Note: (1) HMSA has arranged with contracted drug manufacturers to offer spacers for inhaled drugs and peak flow meters at special member rates.		
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	HMSA Vendor	Non-HMSA Vendor
Generic, Preferred Brand Name, Other Brand Name, Insulin, Diabetic Supplies, Oral Contraceptives, Diaphragms	Any eligible charges exceeding HMSA's \$30 payment under this plan	Not a benefit

MUTUAL BENEFIT ASSOCIATION OF HAWAII

Chiropractic Coverage



Mutual Benefit Association of Hawaii, through ChiroPlan Hawaii, Inc. is the provider of chiropractic benefits. The plan description provided in this summary of benefits shows highlights of the plan benefits. Please refer to the plan certificate for complete information on benefits, provisions, limitations and exclusions. In the event of a discrepancy between these descriptions and the provisions contained in the plan certificate, the latter will govern. A complete list of ChiroPlan doctors and plan information may be obtained from the EUTF website, www.eutf.hawaii.gov.

All three of the medical plan options described on the previous pages include these chiropractic benefits. In order to use these benefits you must use ChiroPlan doctors. ChiroPlan may be contacted at:

ChiroPlan Hawaii, Inc.
711 Kilani Avenue, Suite 3
Wahiawa, HI 96786
Telephone: 808-621-4774
Toll-free: 800-414-8845 (Neighbor Islands)
Fax: 808-621-0006
Website: www.chiroplanhawaii.com

	ChiroPlan Provider	Non-ChiroPlan Provider
Maximum Number of Office Visits Per Calendar Year	20	Not Covered
Office Visit Co-pay	\$15	Not Covered
Therapy Modalities*	No Charge	Not Covered
X-Ray**	No Charge	Not Covered
Lab	Not Covered	Not Covered
Chiropractic Appliances	Not Covered	Not Covered
Emergency/Urgent Care	Not Covered	Not Covered
Out-of-Network	Not Covered	Not Covered
Alternative Medical Services***	Not Covered	Not Covered

* Therapy Modalities Include: Ultrasound, Ice Packs, Heat Packs, Electrical Muscle Stimulation and other approved therapies.


** Routine x-rays: Two (2) views per body region, per calendar year; additional x-rays performed require a \$15.00 co-pay.

*** Alternative Medical Services Includes: Hypnotherapy, Acupuncture, Behavior Training, Sleep Therapy, etc.

Summarized below are the dental benefits provided through Hawaii Dental Service (HDS). For a full description of the benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov, or the HDS Customer Service Department at (808) 529-9248 or toll-free from the neighbor islands and continental U.S. at 1-800-232-2533 extension 248. You may also obtain information from the HDS website, www.deltadentalhi.org.

Beneficiaries who were covered by HDS immediately prior to electing this coverage will have time limitations carried forward for diagnostic and preventive benefits.

Benefit	Plan Coverage
Diagnostic	
Examinations (twice per calendar year)	100%
Bitewing x-rays (twice per calendar year)	100%
Other x-rays (full mouth x-rays limited to once every three years)	100%
Preventive	
Prophylaxes (cleanings - twice per calendar year)	100%
Stannous fluoride (once per calendar year through age 17)	100%
Space maintainers (through age 17)	100%
Sealants (through age 16)	100%
Restorative	
Amalgam fillings	80%
Composite fillings (limited to anterior teeth)	80%
Crowns and Gold Restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	60%
Endodontics	
Pulpal Therapy	80%
Root canal	80%
Periodontics	
Surgical and non-surgical treatment of diseases of the gums and bones	80%
Prosthodontics	
Fixed Bridges (once every 5 years; ages 16 and older)	60%
Dentures (complete and partial - once every 5 years; ages 16 and older)	60%
Implants (covered as alternate benefit)	60%
Oral Surgery	80%
Adjunctive General Services	80%
Palliative	100%
Calendar Year Benefit Maximum*	\$2,000/ person
Calendar Year Deductible**	\$25/person
Orthodontic Benefit	50%
HDS will prorate benefit payments for beneficiaries who started orthodontic treatment prior to July 1, 2003 and are still receiving services. New members enrolled after July 1, 2003, will not receive benefits for treatment started prior to their enrollment.	\$1,000 Lifetime Maximum (\$125 paid quarterly over 2 years)

 The shaded area indicates a 12-month waiting period for major services for new enrollees after July 1, 2003.

* The plan maximum will be prorated to \$1,000 for the initial period beginning July 1, 2003 through December 31, 2003. Effective January 1, 2004 the annual plan maximum will be \$2,000 per person.

** Waived for services covered at 100%.

Dual Coverage Dental Plan



As with the medical plan, you have the option to elect the Dual Coverage Dental plan if you have dental coverage under another dental plan. This plan is also offered by HDS. Please refer to the previous page for contact information.

Beneficiaries who were covered by HDS immediately prior to electing this coverage will have time limitations carried forward for diagnostic and preventive benefits.

Benefit	Plan Coverage
Diagnostic	
Examinations (twice per calendar year)	50%
Bitewing x-rays (twice per calendar year)	50%
Other x-rays (full mouth x-rays limited to once every three years)	50%
Preventive	
Prophylaxes (cleanings - twice per calendar year)	50%
Stannous fluoride (once per calendar year through age 17)	50%
Space maintainers (through age 17)	50%
Sealants (through age 16)	50%
Restorative	
Amalgam fillings	40%
Composite fillings (limited to anterior teeth)	40%
Crowns and Gold Restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	30%
Endodontics	
Pulpal Therapy	40%
Root canal	40%
Periodontics	
Surgical and non-surgical treatment of diseases of the gums and bones	40%
Prosthodontics	
Fixed Bridges (once every 5 years; ages 16 and older)	30%
Dentures (complete and partial – once every 5 years; ages 16 and older)	30%
Implants (covered as alternate benefit)	30%
Oral Surgery	40%
Adjunctive General Services	40%
Palliative	50%
Calendar Year Benefit Maximum	\$800*

* The plan maximum is not prorated for the initial period beginning July 1, 2003 through December 31, 2003.

VSP Vision Plan



Summarized below are the vision benefits provided through Vision Service Plan (VSP). For a full description of the benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov, or the VSP Customer Service Department at (808) 532-1600 or toll-free from the neighbor islands at 800-522-5162 and continental U.S. at 800-877-7195. You may also obtain information from the VSP website, www.vsp.com.

	<i>Network</i>	<i>Non-Network</i>
Eye Exam		
Every 12 Months	\$10 Co-payment	Up to \$40 Benefit
Materials		
Lenses Every 12 Months	\$25 Co-payment	Not Applicable
Single Vision ¹	No Charge	Up to \$40 Benefit
Bifocals ¹	No Charge	Up to \$60 Benefit
Trifocals ¹	No Charge	Up to \$60 Benefit
UV Coating ¹	No Charge	No Additional Benefit
Frame		
Every 24 Months	Covered Up to \$105 Allowance ²	Up to \$40
Contacts		
Every 12 Months	Covered Up to \$100 Allowance ³	Up to \$100

¹ Lens options, which can enhance the appearance, durability and function of your glasses, are available to you at VSP's member preferred pricing.

² If you choose a frame valued at more than your allowance, you'll save 20% on your out-of-pocket cost for frames.

³ Your allowance applies to the cost of your contact lens exam and your contact lenses. You'll receive a 15% discount off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.

Dual Coverage Vision Plan

As with the medical and dental plans, you have the option to elect the Dual Coverage Vision plan if you have vision coverage under another vision plan. This plan is also offered by VSP.

Eye Exam	Plan Pays
Every 12 Months	Up to \$10 Benefit
Materials	
Lenses and/or Frame	Up to \$75 per year

Life Insurance Benefits



Life insurance benefits are underwritten by Aetna Life Insurance Company. This is a summary of the plan benefits. For complete information and provisions, please refer to your certificate or contact Aetna or the EUTF.

Customer Service: 1-866-227-9954 (toll-free)
Claim Office:
Aetna Inc.
Life Service Center
151 Farmington Avenue – RE52
Hartford, CT 06156-3007
Fax Number for Claim Submission: 1-800-238-6239
Website: www.aetna.com

In the event of your death, the life insurance company will pay your beneficiary the applicable amount of life insurance benefits as shown below:

Classification	Benefit Amount
Active employees	
Under age 65	\$26,000
Age 65 through 69	\$16,900
Age 70 through 74	\$11,700
Age 75 through 79	\$7,800
Age 80 and over	\$5,200
Retired employees	\$1,900

The death benefit amount will be reduced by any amount previously paid under the Accelerated Death Benefit provision, described below.

Designation of Beneficiary Form

This booklet contains a Designation of Beneficiary Form and instructions for completing the form. This form must be completed and turned in to your DPO.

Classification Change Date

Any change in your life insurance classification will become effective on the date of your 65th, 70th, 75th, and 80th birthday, or your retirement from active employment.

Accelerated Death Benefit

If, while covered under this life insurance plan you become terminally ill, you may request that the life insurance company pay an Accelerated Death Benefit. Your physician must certify that you suffer from a terminal illness and have a life expectancy of 12 months or less. Upon approval of your request, the insurance company will pay up to 75% of your life insurance benefits, with a minimum payment of \$5,000. A nominal amount of interest is charged for the accelerated payment, as defined in your life insurance certificate. The Accelerated Death Benefit payment will be reduced by an interest discount to account for the early payment.

Life Insurance Conversion

If your life insurance ceases because of termination of employment or is reduced due to age, you may convert to an individual policy. You must apply within 31 days of the following events:

- ▶ Your insurance ends because you are no longer eligible, you may convert to an amount of life insurance equal to the amount of insurance you had prior to your termination.
- ▶ When you reach age 65, 70, 75, and 80 as an active employee and at retirement, you may convert to the amount being reduced.

This conversion option provides 31 days of "free" coverage: If you die within the 31-day conversion period, and before the individual policy goes into effect, the amount payable is the maximum amount you could have converted. This amount applies even if you had not applied for or paid the first premium on the individual policy.

Long-Term Care Plan



Hartford Life

Information about the long-term care plan is being provided even though it is not part of the EUTF's open enrollment. The Public Employees Health Fund arranged for this coverage and its availability is continuing. Since this coverage is a carry-over, it does not include eligibility for domestic partners.

The long-term care insurance plan is underwritten by Hartford Life Insurance Company. Long-term care includes a wide range of supportive, medical, personal and social services for people who need assistance for an extended period of time. The purpose of Long-Term Care is to maintain and/or increase independence by promoting functionality and the ability to care for oneself. Long-Term Care needs may arise at any time due to an injury, illness or the effects of the natural aging process. Services for Long-Term Care can be provided in your home, by your community, a nursing home, an assisted living facility or an alternate care facility.

Long-Term Care insurance is an affordable way to protect against the risk of losing your savings to pay for Long-Term Care services. Most unplanned Long-Term Care costs are paid directly by individuals and their families. This can mean tapping into hard-earned savings or limiting the income available to support a healthy spouse.

The average cost of one year in a nursing home is over \$46,000.¹ Since the average nursing home stay is 2.6 years², nursing home costs can exceed \$100,000. This is expected to rise at an average annual rate of 3% above the overall rate of inflation. If this trend continues, the annual cost of a nursing home stay will increase from \$46,000 to \$69,000 by 2015. Without Long-Term Care protection you may lose everything you've worked a lifetime to save.

The following persons, ages 20 through 85 are eligible to enroll in the program on a **voluntary, self-pay basis**:

1. State and County employees (employed for three months and at least a 50% full-time position) and retirees, as well as
 - A. Their spouses
 - B. Their parents and parents-in-law
 - C. Their grandparents and grandparents-in-law
2. The surviving spouses of deceased retirees or employees killed in the performance of duty

There is no automatic enrollment for this coverage. **You must file a separate enrollment application and pay monthly premiums directly to Hartford Life Insurance Company.** Newly hired employees will be offered a 90-day enrollment period as well.

To receive the necessary enrollment materials, please call (808) 524-1372 (neighbor islands may call toll-free 1-866-299-1234) or FAX your request to 1-888-565-1560. Be sure to include your name, address, city, state, zip, phone number and active or retiree designation.

You may also visit <http://www.healthfundltc.com> to email a request for enrollment materials.

¹ Health Insurance Association of America, 1999

² New England Journal of Medicine, 1991

Plan Information at a Glance

Total Coverage	The Applicant chooses either a three-year plan or a five-year plan.
Daily Benefit Amounts	<p>The Applicant chooses one of the daily benefit amounts:</p> <ul style="list-style-type: none"> ▶ \$100 per day for Nursing Home Care; \$75 per day for Assisted Living Facility Care and Residential Care Homes; and \$50 per day for Home Care; or ▶ \$150 per day for Nursing Home Care; \$112.50 per day for Assisted Living Facility Care and Residential Care Homes; and \$75 per day for Home Care; or ▶ \$200 per day for Nursing Home Care; \$150 per day for Assisted Living Facility Care and Residential Care Homes; and \$100 per day for Home Care. <p>Note: According to the Hartford, a semi-private room in a nursing home in Hawaii averages \$181 per day.</p>
Available Coverage	Comprehensive includes: Nursing Home Care, Home Health Care, Adult Day Care, Respite Care, Assisted Living Facilities, Residential Care Homes and Supportive Services.
Deductible Period	Ninety (90) calendar days once per lifetime.
Return of Premium Upon Death Benefit	If death occurs at age 65 or earlier, 100% of premiums are returned, less any benefits paid. The amount of premium decreases by 10% each year after age 65, with no premium returned if death occurs at age 75 or later. The applicant may decline this benefit at the time of application.
Nonforfeiture Benefit	This benefit provides for continuation of your coverage on a limited basis if you elect to voluntarily terminate coverage after paying premiums for at least 36 months. The applicant may decline this benefit at the time of application.
Inflation Protection Option	<p>Periodic Benefit Increases – at least every 3 years you will be offered an option to increase coverage for an additional premium amount; this option is automatically included in the Health Fund program.</p> <p>Automatic Inflation Protection – built-in 5% compounded annual increases in coverage with level premiums; the applicant may accept or decline this option at the time of application.</p>
Advisory Services	Available to help develop a plan of care and to identify quality providers.
Benefit Eligibility	Loss in 2 out of 6 Activities of Daily Living or severe cognitive impairment.
Portability	Coverage is fully portable to anywhere in the United States.
Rates	Rates are based on you age when your application is received. They are designed to remain level over your lifetime and can only be changed on a class basis not because of an individual's age or illness.
Guaranteed Renewable	Your coverage can never be canceled as long as you continue to pay your premiums when due.

Important Notices

Many federal and state laws guide the administration of all health benefits insurance plans. While official insurance contracts actually govern your rights and benefits under each plan in which you are enrolled, the following information is provided to help you understand your statutory rights and benefits. If any discrepancy exists between the information provided in this section and your official insurance documents, the official insurance documents will prevail.

If you have any questions about this section, please call the Hawaii Employer-Union Health Benefits Trust Fund (the EUTF) at 808 586-7390.

Women's Health & Cancer Rights Act

Your health insurance plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy-related services, including:

- ▶ Reconstruction of the breast on which the mastectomy has been performed
- ▶ Surgery and reconstruction of the other breast to produce a symmetrical appearance
- ▶ Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Your plan will provide coverage in consultation with the attending physician and patient.

Coverage for breast reconstruction and related services will be subject to deductibles, co-payments, and coinsurance amounts that are consistent with those that apply to other benefits under the Plan. If you have any questions about the Women's Health and Cancer Rights Act, please call your insurance carrier or the EUTF at 808-586-7390.

Newborns' & Mothers' Health Protection Act

Generally, group health plans and health insurance issuers who offer group insurance coverage may not (under federal law) restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to:

- ▶ Less than 48 hours following a normal vaginal delivery, or
- ▶ Less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a hospital stay not in excess of 48 hours (or 96 hours). However, the Plan may still require pre-certification of any hospital admission in connection with childbirth, in order for you to obtain the maximum level of benefits available under the Plan.

Qualified Medical Child Support Order

Your health insurance plan honors qualified medical child support orders (QMCSOs). This means that if a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so under the Plan. To be qualified, a medical child support order must include:

- ▶ Name and last known address of the parent who is covered under the health insurance plan,
- ▶ Name and last known address of each child to be covered under the health insurance plan,
- ▶ Type of coverage to be provided to each child, and
- ▶ Period of time coverage will be provided.

Send QMCSOs to the EUTF, which is your Plan Administrator. Upon receipt, the EUTF will notify you and give you the procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan.

National Medical Support Notices

The EUTF (your health benefits plan administrator) also honors qualified National Medical Support Notices (NMSNs). These Notices are similar to a QMCSO, but are issued by a state agency pursuant to a medical child support order. Upon receipt of the NMSN, the Employer will, within 40 business days, return the Notice to the state agency if the specified coverage is not available for one of the reasons set forth on the Notice, or forward the Notice to the EUTF, the Plan Administrator, if the specified coverage is available.

If the Employer forwards the Notice to the EUTF, the EUTF will, within 40 business days, return the Notice to the state agency and/or the parties concerned to inform them whether the Notice constitutes a QMCSO.

If the Notice qualifies, the EUTF will notify the state agency either that the child(ren) is/are currently enrolled

or will be enrolled in the coverage available under the EUTF.

If you are not enrolled and there is more than one coverage option available, the EUTF will inform the state agency of the coverage options from which you may elect coverage. In this event, the EUTF will also notify your employer, who will determine whether federal or state withholding rules permit withholding from your salary or wages the amount required to provide coverage to the child(ren) under the terms of the health insurance plan, and, if so, to withhold the required amounts from your pay for such coverage and remit these amounts withheld to the EUTF.

If the Notice is not qualified, then within 40 business days, the EUTF will notify the state agency and the parties involved, the specific reason(s) why the Notice failed to qualify. The EUTF may also provide additional notifications as provided for in the NMSN's instructions

Continuation of Group Health Coverage Under COBRA: Initial Notice

A federal law, commonly known as "COBRA," requires most employers to offer employees and their covered dependents the opportunity to elect a temporary continuation of health coverage, at group rates, when coverage would otherwise be terminated, because of a "qualifying event" (listed below).

The section serves as your initial notice of your rights and obligations under COBRA. It is subject to change without warning, as interpretations or changes in the law do occur. Please read this notice carefully, share it with your family, and keep it in your file.

Qualifying Events

Employees

If you are an employee covered under a group health plan, you (and your covered dependents) may elect COBRA coverage if you lose your group health coverage due to either of these "qualifying events":

Termination of your employment (for reasons other than gross misconduct), or

Reduction in your work hours causing you to be ineligible for health benefits insurance.

Covered Spouses

If you are the covered spouse of an employee enrolled in a group health plan, you may elect COBRA coverage if you lose group health coverage due to any of these "qualifying events":

Termination of your spouse's employment (for reasons other than gross misconduct), or reduction in your

spouse's work hours causing him or her to be ineligible for Plan benefits,

Death of your spouse,

Divorce or legal separation from your spouse, or

Employee-beneficiary becomes entitled to Medicare benefits.

Covered Children

Dependent children who are covered under a group health plan have the right to elect COBRA coverage if they lose coverage under the Plan due to any of these "qualifying events":

- ▶ The employee-parent's employment stops (for reasons other than gross misconduct), or work hours are reduced resulting in ineligibility for Plan benefits,
- ▶ Death of the employee-parent,
- ▶ Parents' divorce or legal separation,
- ▶ Employee-parent becomes entitled to Medicare benefits, or
- ▶ Dependent child ceases to be a "dependent child" under the health insurance plan.

Obtaining COBRA Coverage

If your employment terminates, the EUTF will automatically send you a COBRA continuation notice. However, if you get divorced or legally separated, or if your dependent child no longer meets the eligibility requirements under the Plan, you or your dependents must notify the Plan Administrator and request COBRA coverage. You must make this request within 60 days of the qualifying event. If you fail to give this notice within the 60-day period, your spouse and any covered dependent that loses coverage will NOT be offered COBRA coverage. Also, if you fail to give this notice and your insurance carrier mistakenly pays claims for expenses incurred after the date your coverage is supposed to end because of one of these qualifying events, then you, your spouse or your covered children will have to reimburse your insurance carrier for any claims so paid.

You will have 60 days from the date the EUTF provides you opportunity to enroll through COBRA, to make a decision about your COBRA options. If you, your spouse, or dependents do not choose COBRA coverage within this 60-day period, you will lose the right to elect COBRA coverage completely.

A covered employee or the spouse of the covered employee may elect continuation coverage for all family members. However, each covered person has an independent right to elect COBRA coverage. A covered spouse or covered dependent child may elect

continuation coverage even if the covered employee does not.

You do not have to show that you are insurable to choose continuation coverage. However, COBRA coverage is provided subject to the individual's eligibility for coverage. Your Employer reserves the right to terminate COBRA coverage retroactively if someone is determined to be ineligible for coverage under the Plan.

Adding New Dependents After Coverage Begins

If you have already elected COBRA, and you have a life event, such as marriage, birth, adoption, placement for adoption, or you have declared a domestic partner, or, if an eligible dependent declines coverage under the Plan because of other coverage and later loses such other coverage due to certain qualifying events — you may add your new spouse/domestic partner, newborn children and adopted children, or the previously covered dependent(s) to your COBRA coverage within 30 days of the event.

Cost of Coverage

Insurance carriers providing coverage for the EUTF beneficiaries will administer the billing and collection of COBRA premiums.

You will be charged the full premium under the group health plan for COBRA coverage, plus a 2% administrative charge. If you are disabled and you extend your coverage for more than 18 months, you will have to pay the full cost of coverage plus another 50% of the premium for months 19 through 29.

You may pay for COBRA coverage on a monthly basis. Your first payment will cover the period from the date your former coverage terminated to the date you elect COBRA coverage — and is due within 45 days of your COBRA election date. The EUTF will give you specific cost information at that time. For subsequent premium payments, you have a grace period of 30 days for payment of the regularly scheduled premium. If you fail to pay the full monthly premium amount when due, your COBRA coverage will be terminated for non-payment. If this happens, you will not be allowed to reinstate your COBRA coverage.

Maximum Coverage Periods

Under COBRA, the maximum coverage periods are:

18-Months – For group health coverage lost due to the employee's termination of employment (other than for gross misconduct) or reduction in hours. There are two exceptions:

- ▶ **Totally Disabled Individuals:** The 18-month period may be extended to 29 months if an Employee or

dependent is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11-month extension is available to all individuals who are covered under COBRA due to a termination or reduction in hours of employment. To receive this extension, the employee or dependent must notify the Employer or the EUTF within 60 days of the Social Security Administration's total disability determination, and before the end of the initial 18-month period. The affected individual must also notify the EUTF, the Plan Administrator, within 30 days of any final determination that the individual is no longer disabled.

- ▶ **Second Qualifying Event Occurs:** If a second qualifying event (such as the employee's death or divorce) occurs during the 18-month or 29-month coverage period, the initial maximum coverage period of 18 months may be extended to 36 months from the date of the initial qualifying event.

36 Months – If you are a spouse or a dependent child and you lose group health coverage because of the employee's death, divorce, legal separation, or the employee's becoming entitled to Medicare benefits, or because you lose your status as a dependent child under the Plan.

Special Rule Regarding Medicare

If you enroll for Medicare before you terminate employment or before you lose full-time status, your covered spouse and dependents may continue COBRA coverage for 36 months from the date the employee became entitled to Medicare.

When Coverage Ends

Your COBRA coverage will terminate automatically before the maximum coverage period ends, when any of the following events occur:

- ▶ Your Employer no longer provides group health coverage to any of its employees.
- ▶ Payment of any required COBRA premium is not received within 30 days of its due date.
- ▶ After electing COBRA, you become covered under another group health plan (as an employee or a dependent), which does not contain any exclusion or limitation with respect to any pre-existing condition you have.
- ▶ After electing COBRA, you or your dependents become entitled to (enrolled in) Medicare.
- ▶ You became entitled to a 29-month maximum coverage period, but then the Social Security

Administration determines that you or your dependents are no longer disabled.

Once COBRA coverage is cancelled, it will not be reinstated.

Rights and Benefits

COBRA participants in a health insurance plan have the same rights and benefits as active participants in the plan. Any changes made to the plan for active participants will also apply to COBRA participants.

HIPAA Initial Notice: Notice of Privacy Rules

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

A federal law, commonly known as HIPAA (the Health Insurance Portability and Accountability Act of 1996) governs all group health plans' use and disclosure of medical information. You may find HIPAA's privacy rules at 45 Code of Federal Regulations Parts 160 and 164.

This notice summarizes these regulations, describes the EUTF's obligations, and your rights regarding the uses and disclosures of your medical information.

The EUTF acknowledges that your medical and health information is personal - and is committed to protecting your privacy.

For administration purposes, the EUTF has access to a record of your claims reimbursed under your health insurance benefits plan. This notice applies to all of the medical records that the EUTF maintains or can access. Your personal doctor, health care provider, or health insurance carrier might have different policies or notices regarding their use and disclosure of medical information that they maintain or create. However, HIPAA applies to all organizations and persons that maintain personal health information, if they fall under HIPAA's definition of "Covered Entities."

By law, the EUTF MUST:

- ▶ Make sure that medical information that identifies you is kept private,
- ▶ Give you this notice of the EUTF's legal duties and privacy practices with respect to your medical information,
- ▶ Retain copies of the notices the EUTF issues to you,
- ▶ Retain any written acknowledgments that you received the notices, or document the Plan's good faith efforts to obtain such written acknowledgments from you, and

- ▶ Follow the terms of the notice that is currently in effect.

HIPAA also requires the EUTF to tell you about:

- ▶ The EUTF's uses and disclosures of your medical information,
- ▶ Your privacy rights with respect to your medical information,
- ▶ Your right to file a complaint with the EUTF and with the Secretary of the Department of Health and Human Services, and
- ▶ The person or office at the EUTF whom you may contact for additional information about the EUTF's privacy practices.

How the Plan May Use and Disclose Your Medical Information

The following categories describe the different ways the EUTF may use and disclose your medical information. Some uses and disclosures require your authorization or opportunity to agree or object to the use or disclosure. Other uses and disclosures do not. This notice clearly identifies whether or not the use or disclosure of your medical information requires your authorization or the opportunity to agree or object. Each category contains an explanation of what is meant by the "use and disclosure" of your medical information, and some examples. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is allowed to use and disclose your medical information will fall into one of the categories listed.

The following categories DO NOT REQUIRE the Plan to obtain your consent, authorization, or to provide you the opportunity to agree or object to the use or disclosure.

For Treatment: the EUTF may use or disclose your medical information to help you get medical treatment or services through the EUTF. The EUTF may disclose your medical information to health care providers, including doctors, nurses, technicians, medical students, or other health care professionals who are providing you with services covered under your insurance plan. For example, the EUTF might disclose the name of your child's dentist to your child's orthodontist so that the orthodontist may ask the dentist for your child's dental X-rays.

For Payment: the EUTF may use and disclose your medical information in the process of determining your eligibility for benefits under the EUTF, to facilitate payment to health care providers for the treatment or services you have received from them, to determine benefit responsibility under the EUTF, and to facilitate reviews for medical necessity/appropriateness of your care. For example, the EUTF may tell your doctor

whether you are eligible for coverage under the EUTF, or what percentage of the bill may be paid by the EUTF. Likewise, the EUTF may share your medical information with another entity to assist with the adjudication or subrogation of your claims or to another health Plan to coordinate benefit payments.

For the EUTF Operations: the EUTF may use and disclose your medical information for other the EUTF operations. These uses and disclosures are necessary to administer the EUTF benefit plans and include using your medical information in conducting quality assessment and improvement activities, for underwriting, premium rating, and other insurance activities related to creating or renewing insurance contracts. Health care operations also include disease management, case management, conducting or arranging medical reviews, legal services, and audit functions, including fraud and abuse detection programs, business planning and development, and other activities related to business management and the EUTF administration. For example, the EUTF may use your medical information to audit the accuracy of its claim processing functions.

As Required By Law: the EUTF will disclose your medical information when required to do so by federal, state or local law. For example, the EUTF may disclose your medical information when required to do so by a court order in a civil proceeding such as a malpractice lawsuit. Or, the Secretary of the Department of Health and Human Services might require the use and disclosure of your medical information to investigate or determine the EUTF's compliance with federal privacy regulations (this notice).

To Avert a Serious Threat to Health or Safety: the EUTF may use and disclose your medical information when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. However, any such disclosure would be made only to a person able to help prevent the threat. For example, the EUTF may disclose your medical information in a legal proceeding regarding the licensure of a doctor.

Special Situations

Disclosure to Business Associates: the EUTF may disclose your medical information to business associates in carrying out treatment, payment or health care operations. For example, the EUTF may disclose your medical information to a utilization management organization to review the appropriateness of a proposed treatment under your insurance plan. In addition, the EUTF personnel may use your medical information solely for the purposes of administering benefits under the EUTF.

Organ and Tissue Donation: If you are an organ donor, the EUTF may release your medical information to

organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, the EUTF may release your medical information as required by military command authorities. The EUTF may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: the EUTF may release your medical information for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health Oversight Activities: the EUTF may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities can include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, the EUTF may disclose your medical information in response to a court order or administrative ruling. The EUTF may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the medical information requested.

Law Enforcement: the EUTF may release your medical information if asked to do so by a law enforcement official:

- ▶ In response to a court order, subpoena, warrant, summons or similar process,
- ▶ To identify or locate a suspect, fugitive, material witness, or missing person,
- ▶ About the victim of a crime if, under certain limited circumstances, the EUTF is able to obtain the person's agreement,
- ▶ About a death the EUTF believes might be the result of criminal conduct, and
- ▶ In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: the EUTF may release your medical information to a coroner or medical examiner. This might be necessary,

for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities: the EUTF may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

The following category **REQUIRES** the Plan to obtain your written authorization for the use or disclosure.

Psychotherapy Notes: Generally the EUTF must obtain your written authorization to use and disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the EUTF may use and disclose your psychotherapy notes when needed by the EUTF to defend against a lawsuit filed by you.

The following category **REQUIRES** that the EUTF gives you an opportunity to agree or disagree prior to the use or disclosure.

Family or Friends Involvement: the EUTF may disclose your medical information to family members, other relatives, or your friends if:

- ▶ The medical information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- ▶ You have either agreed to the disclosure or have been given the opportunity to object to the disclosure and have not objected.

Your Rights Regarding Your Medical Information

You have the following rights regarding your medical information maintained by the Plan:

Right to Inspect and Copy Your Medical Information: You have the right to inspect and obtain a copy of your medical information contained in a "designated record set," for as long as the EUTF maintains your medical information. The designated record set includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health Plan; or other information used in whole or in part by or for the EUTF to make decisions about people covered under the EUTF health benefits plans. Information used for quality control or peer review analyses and not used to make decisions about people covered by the EUTF health benefits plans is not contained in the designated record set.

If you request a copy of your medical information, it will be provided to you within 30 days, if the EUTF maintains

the information on-site, or within 60 days, if the information is maintained off-site. If the EUTF is unable to comply within these time limits, it may request a one-time extension of up to an additional 30 days in order to provide the requested information.

You or your personal representative must complete a form to request access to your medical information contained in the designated record set. You must submit the completed request form to the EUTF Administrator whose address is provided at the end of this HIPAA notice.

If you request a copy of the information, the EUTF may charge a fee for the costs of copying, mailing or other supplies associated with complying with your request.

The EUTF may deny your request to inspect and copy medical information in certain, very limited circumstances. If you are denied access to medical information, you may appeal.

If the EUTF denies your request to inspect or copy your medical information, the EUTF will provide you or your personal representative with a written denial identifying the reason(s) for the denial. The denial will also include a description of how you may exercise your appeal rights, and a description of how you may file a complaint with the Secretary of the Department of Health and Human Services.

Right to Amend Your Medical Information: If you think that your medical information is incorrect or incomplete, you may ask the EUTF to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the EUTF.

To request an amendment, you must submit your request, in writing, to the EUTF Administrator. Your written request must include a reason that supports your request.

After you request that the EUTF amend your medical information, the EUTF must comply with your request within 60 days, or notify you that your request has been denied. The EUTF may extend this for up to an additional 30 days, if it is unable to comply with your request within the initial 60-day period.

The EUTF may deny your request for an amendment to your medical information if your request is not in writing or does not include a reason to support the request. In addition, the EUTF may deny your request if you ask it to amend information that:

- ▶ Is not part of the medical information kept by or for the EUTF,
- ▶ Was not created by the EUTF, unless the person or entity that created the information is no longer available to make the amendment,

- ▶ Is not part of the information which you would be permitted to inspect and copy, or
- ▶ Is accurate and complete.

If the EUTF denies your request in the whole or in part, the EUTF must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial, and have that statement included with any future disclosure of your medical information.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" if a disclosure was made without your authorization for any purpose other than treatment, payment, or health care operations, or where the disclosure was to you about your own medical information.

To request this list of disclosures, you must submit a written request to the EUTF Administrator. Your request must state a time period for which you are requesting the list of disclosures. This period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, the EUTF may charge you for the costs of providing the list. The EUTF will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any costs.

the EUTF has 60 days from the date of your request to provide you the list of disclosures, and is allowed an additional 30 days to comply, if it provides you with a written statement of the reasons for the delay and the date by which the accounting will be provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on your medical information uses or discloses for treatment, payment or health care operations. You also have the right to request a limit on your medical information that the EUTF discloses to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgical procedure you had.

The EUTF is not required by law to agree to your request.

You or your personal representative must complete a form to request restrictions on the use or disclosure of your medical information. You must submit the completed form to the EUTF Administrator whose address is provided at the end of this HIPAA notice.

In your request, you must indicate:

- ▶ What information you want to limit,

- ▶ Whether you want to limit the EUTF's use, disclosure, or both, and
- ▶ To whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that the EUTF communicate with you about your medical information or other medical matters in a certain way, or at a certain location. For example, you may ask that the EUTF contact you only at work or by mail.

To request confidential communications, you must submit a written request to the EUTF Administrator. The EUTF will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how and/or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice. You may ask the EUTF to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to receive a paper copy of this notice.

To obtain a paper copy of this notice, submit a written request to the EUTF Administrator, whose address is provided at the end of this HIPAA notice.

A Note about Personal Representatives

You may exercise your privacy rights through a personal representative. Your personal representative will be required to provide evidence of his or her authority to act on your behalf before that person will be given access to your medical information or allowed to take any action on your behalf with respect to your medical information. Proof of such authority may take one of the following forms:

- ▶ A power of attorney for health care purposes, notarized by a notary public,
- ▶ A court order appointing the person as your conservator or guardian, or
- ▶ An individual who is the parent of a minor child.

The EUTF may decide to deny a personal representative access to medical information of a person if it thinks this will protect the person represented from abuse or neglect. This also applies to personal representatives of minors.

However, state or other applicable law will govern whether the EUTF is permitted to disclose an unemancipated minor dependent child's medical information to the child's parent(s). State or other applicable law will also govern whether the EUTF is permitted to provide a parent's access to his or her child's medical information.

Changes to This Notice

The EUTF reserves the right to change this notice. The EUTF also reserves the right to make the revised or changed notice effective for medical information it already maintains, or has access to about you — as well as any information the EUTF receives in the future. The EUTF will post a copy of the current notice on the EUTF's web site. This notice will contain the effective date of the current notice on the first page, in the top right-hand corner.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your rights, the duties of the EUTF or other privacy practices stated in this notice.

Minimum Necessary Standard

When the EUTF uses or discloses your medical information, or requests your medical information from another entity, the EUTF will make reasonable efforts not to use, disclose or request more than the minimum amount of your medical information needed to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply to:

- ▶ Disclosures to or requests by a health care provider for treatment,
- ▶ Uses by you or disclosures to you of your own medical information,
- ▶ Disclosures made to the Secretary of the Department of Health and Human Services,
- ▶ Uses or disclosures that may be required by law,
- ▶ Uses or disclosures that are required by the EUTF's compliance with legal regulations, and
- ▶ Uses and disclosures for which the EUTF has obtained your authorization.

This notice does not apply to information that has been "de-identified." De-identified information is medical information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the EUTF may use or disclose "summary health information" to obtain premium bids or to modify, amend or terminate the EUTF's health benefits plans. Summary health information is information that summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom the EUTF has provided benefits, and from which identifying information has been deleted in accordance with the

Health Insurance Portability and Accountability Act (HIPAA).

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the EUTF Administrator, whose address is provided at the end of this HIPAA notice.

You may also file a complaint with the Secretary of the Department of Health and Human Services at:

Secretary, DHHS
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

You must submit any complaints in writing. The EUTF will not penalize or retaliate against you for filing a complaint.

Other Uses of Your Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the EUTF will be made only with your written permission. If you provide the EUTF with permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, the EUTF will no longer use or disclose your medical information for the reasons covered by your written authorization. You should understand that the EUTF is unable to take back any disclosures that have already been made with your permission, and that the EUTF is required to retain any records regarding any care or services it provided to you.

Questions?

If you have any questions about this notice, please contact the EUTF Administrator, whose address is provided at the end of this HIPAA notice.

Governing Law

If there is any discrepancy between the information in this notice and the actual HIPAA regulations, the regulations will prevail, and the EUTF will use and disclose your medical information in a manner consistent with the regulations.

You may contact the EUTF Administrator at the following address:

The EUTF Administrator
P.O. Box 2121
Honolulu, HI 96805
Tel: (808) 586-7390
Fax: (808) 586-2161
Email: eutf@hawaii.gov